SSI Dane County Managed Care Advisory Committee
Minutes
9/24/04

Attendance:

Peggy Michaelis, Dane Co. Redesign
Jeff Erlanger
Jim Maddox, Redesign/NAMI/Mental Health Center of Dane County (MHCDC)
David LeCount, Dane County Department of Human Services (DCDHS)
Jenny Lowenberg, NAMI
Tom Lawless, The Management Group Inc. (TMG)
Ginny Graves, TMG
William Greer, MHCDC
Tim Otis, MHCDC
Todd Costello, Community Living Alliance, Inc. (CLA)
Dan Lowndes, CLA
Owen McCusker, CLA
Fran Genter, DCDHS
Joyce Allen, DHFS/BMHSAS
Michael Fox, DHFS/BMHCP
Angela Dombrowicki, DHFS/BMHCP
Michell Urban, DHFS/BMHCP
Mary Laughlin, DHFS/BMHCP
Angelo Castillo, DHFS/BMHCP
Cindy Booth, DHFS/BMHCP
Albert Lanier, DHFS/BMHCP
Heidi Herziger, DHFS/BHCSO
Peg Algar, DHFS/BMHCP

I. Review of the Minutes from Last Meeting

No comments were made on the minutes. They were accepted into the record and will be posted on the web page, along with other documents from our committee work. The web page address is: http://dhfs.wisconsin.gov/medicaid7/index.htm#medicaid

II. Review of Advisory Committee Issue Log

The following clarifications were made regarding items on the Issue Log*:

- *Capitation methodology and payments need to be determined.* A Rate Setting workgroup is meeting on a regular basis.

- *The Contract Crosswalk needs to be completed and a draft contract developed.* The crosswalk being developed by TMG is for quality assurance measures. It was suggested that the MH/AODA redesign be included in the crosswalk.

- *Consumer input into policies and procedures needs to occur.* Jeff Erlanger, a person with a physical disability, has joined our advisory committee and the quality assurance workgroup. Peg is waiting to hear back from the deaf community whether they can recommend a representative to join our advisory committee or a workgroup.

- *An implementation workgroup will need to be created, with representation from EDS and operations.* We already have an internal SSI workgroup made up of State staff that meets on a weekly basis.

*A copy of the updated log will be attached to this document.

Comments:

- Managed care is a mechanism or tool to further our goal to serve the target population. Some pieces are structural like blending funding streams. An important question is how do we make the system easy to navigate for consumers.

- The crosswalk should identify who will not be eligible for the program.

- The county is concerned about a possible lack of coordination between systems at that level, e.g. Some people in CSPs would be eligible for the managed care program and some would not. Would this create inconsistency in the quality or approach of service delivery?

- The MHCDC and CLA would like to do further outreach to consumers on the proposed program in informational meetings.

- Whatever enrollment type is chosen, consumers should be involved in outreach.

  Reponse: There is much consumer involvement on the products from the workgroups involved at this point.

- Enrollment issues, data issues, sub-contracting and billing issues need to be crosswalked between the current system and the proposed system to assess what all would be involved.

- Michael Fox brought up the question of what happens if after we start, one of the partners withdraws?

Responses:

- ✓ The group came together very committed to better integrate acute primary and mental health/AODA services. Integration is a core principle of the initiative.

- ✓ The goal is to make the 3 programs transparent to consumers. Currently because of different funding streams there exists a disconnect. Need to look at initiative as a development process to interweave the physical disability system, the mental health system and the acute primary care system.

- ✓ The three partners are excited about working together, but not at all costs.

- ✓ We need to keep our minds open on issues and be willing to revisit them, not just back away from the table.

- ✓ The County has a sum certain amount of money and CSP waiting lists. We hope that the people on waiting lists get access with managed care. Blending the funding streams is key.

- ✓ We view managed care as the next developmental step, given budget realities.

- ✓ Need to examine what costs are associated with people on waiting lists. A question that needs to be answered is whether people are receiving services that are not really needed.

- ✓ Need to keep in mind that individuals with mental illness need to be identified when their parents die, as they could be switched from SSI to Social Security.

III. Enrollment Models

Michael Fox presented an issue paper on enrollment options for the Dane SSI Managed Care Initiative. Michael prefaced his presentation with a couple of issues that are germane to the success of any approach used:

1. The importance of the informing process is not mentioned in the paper, but is a very important factor.

2. A balance between providing a maximum amount of consumer choice and achieving a critical mass in terms of enrollment for the MCO is key to a successful implementation.

Options

The Advisory Committee needs to recommend to the Department's Steering Committee one of the following three options for enrollment into the Dane County SSI Managed Care Program:

1. Voluntary Enrollment--Permit all eligible SSI-Medicaid adults to voluntarily enroll in managed care, and disenroll at any time.

2. Universal Enrollment--Enroll all SSI-Medicaid adults into managed care strictly on a universal basis. This process could be implemented following a phase of voluntary enrollment, or an all in/opt out phase, or it could be implemented at the start-up of the program with an approved State Plan Amendment.

3. All In/Opt Out Enrollment--SSI-Medicaid adults would be required to enroll in the Dane County Managed Care Initiative for a minimum of one month. After the one-month enrollment trial period, the enrollee may opt out and return to FFS. A variation of this option would allow a longer period in which to disenroll. If the enrollee does not opt out after one month, the enrollee would be locked into the managed care program for eleven months.

Comments:

- At the end of the lock-in period, what happens?

  Response: The enrollee may stay in the MCO or return to fee-for-service.

- Could the State provide some data on reasons for disenrollments from iCare? What are the reasons people opt-out?

  Response: Data will be provided before our next meeting.

- A clause about guarding against "cherry picking" should be included in the contract.

  Response: For existing programs, the State must approve any disenrollment requested by the MCO. In addition, enrollees have the right to appeal their disenrollment to the State.

- The contract also needs to address the IMD issue.

  Response: OSF sent out a memo addressing the responsibilities of HMOs, counties, and IMDs for children's admissions. Medicaid does not reimburse for services provided in IMDs to adults between the ages of 21 and 64. The memo will be provided as a handout for the next meeting.

- The current HMO contract spells out responsibilities related to IMDs.

- We don't want to impose unwanted services, but want to provide services when medically necessary.

- Automated Health Services Inc. (AHSI) is currently the enrollment broker for BadgerCare.

- Data from the Center for Healthcare Strategies suggests that other states have more outreach for their Medicaid managed care programs.

  Response: Wisconsin uses an enrollment contractor and EDS (the fiscal agent) has technical specifications for outreach. Community-based outreach is also critical to getting information to the right people.

- Its critical that potential enrollees have general knowledge regarding how to access the system.

- A Resource Center could help bridge any gaps regarding information about the program and how to negotiate the system. It could also address the unique characteristics of consumers.

  Response: Just a reminder that there is a Federal requirement that MCOs and providers cannot market for Medicaid funded programs. Usually, an independent enrollment broker informs enrollees of available services and how to access the system. This provides a uniform and unbiased approach to informing enrollees. The Plan needs to make contact with individuals after enrollment.--This is critical to the success of the program.

- Is there anyway that an enrollee with universal enrollment can get back into FFS?

  Response: The only way that type of enrollee could get back into FFS would be through an exemption specified in the contract.

- With the All In/Opt-Out model why would a person have to be in managed care for 30 days if they don't want to be in managed care at all?

  Response: Putting everyone in requires people to try it out. Managed care offers no co-pays, transportation and in some cases better access to services. If at the end of 30 days they don't like managed care, they could opt out back into FFS.

- Out-of-network providers could then balance bill, couldn't they?

  Response: The only way a provider can legally balance bill is if the provider is not Medicaid certified. Any provider certified by the Wisconsin Medicaid Program is prohibited by law from billing recipients.

- What if the MCO disagrees with MA certification of certain providers and do not want the provider in their network?

  Response: The MCO has the right to contract with providers as they choose. They are not required to contract with all Medicaid-certified providers.

- There were problems with iCare at the beginning when enrollees didn't even know they were in a different program.

- An important issue has to do with building networks. If the model is utterly voluntary it will be difficult to build an efficient provider network, because there would not be a way to predict how many recipients will enroll.

  Response: All In/Opt-Out gives the member the opportunity to experience the plan and gives the plan the opportunity to prove its usefulness to the enrollee.

- Not all advocates are against the All In/Opt-Out model. A mandatory model would be harder to sell to advocates.

- Many managed care systems work well. They save money with efficiency and provide access to good primary care physicians and dentists.

- FFS also has the problem of a lack of accountability for quality care. Managed care has safeguards to ensure access to providers and quality care for enrollees.

  Response: The State will intervene on behalf of enrollees at the highest levels of MCO management if necessary. FFS has no such safeguard.

Resolution

The advisory committee decided to recommend the All In/Opt-Out model for the Dane Co. Managed Care Program. It was suggested that an open enrollment period be used instead of rolling disenrollment.

IV. Lessons Learned From iCare

Peg gave a power point presentation on some of the lessons learned during the early days of iCare, when there were several changes in the enrollment process. (See attached power point presentation.)

The following consequences of shifting enrollment were cited by a 1996 analysis performed by the Human Services Research Institute:

- "Default in" enrollment:
  - ✓ More persons enrolled.
  - ✓ Created confusion and concern among enrollees and advocates.

- Strictly voluntary with no "default in" (telemarketing allowed by iCare):
  - ✓ Addressed consumer concerns.
  - ✓ Resulted in a slower enrollment rate and adverse selection.

- Two managed care options:

- ✓ More consumers heard about iCare.
- ✓ Target population drifted (case mix varied from targeted population).

- Strictly voluntary with no "default in" (restrictive on marketing).
  - ✓ Slower enrollment and selection bias.

It should be noted that these observations were based on six months of data. Since then outcomes have improved for the program. The program has reduced rates of hospitalization for a number of chronic conditions. There also has been a reduction in nursing home admissions. The program has maintained high levels of overall member satisfaction. The difference in case mix has been addressed by a stratified capitation rate.

V. Predictive Modeling

Don Libby presented the predictive model designed to predict cost and utilization for Medicaid enrollees. The model takes Medicaid claims data and boils it down into an overview of individuals. One of the reports generated lists past expenditures, high expenditures, and predicted increases in expenditures.

- The goal of the model is to give advance warning of probability of high costs. It uses one year of historical data to predict next year's costs.

- The model is not available on line yet. A resource estimate for making it web-accessible is under way. When the model is available through the web, anyone with access will be able to look at claims for further detail.

- Pharmacy measures are still being developed.

- Don will bring in a list of variables that could be added to the model. Committee members may e-mail any ideas on what variables should be added to Don at: libbydl@dhfs.state.wi.us

- Don reviewed a handout that listed CDPS group codes and how they are related to healthcare costs. This gave examples high versus low-cost diagnoses.

- There is need for fine-tuning of the model. Averages for the whole group of Medicaid recipients are more accurate that individual profiles.

- The next step is to review the model in the Quality Assurance workgroup. The QA workgroup will follow-up on the pharmacy data as an "Early Warning" indicator.

VI. Informing Materials

Mary Laughlin reviewed the informing materials currently used for the iCare and BadgerCare programs. Some of the materials may be replicated for this initiative. Contact Peg if you would like a copy of the informing materials.

- It was suggested that a consumer advisory committee for enrollment informing materials be created.
  - ✓ The All In/Opt-Out approach requires strong outreach to enrollees.
  - ✓ The enrollment broker needs to prioritize whom to do outreach to.
  - ✓ Recipients should have to sign a form to opt in or out.
  - ✓ Consumers involved in working on informing materials need to be trained on managed care.

VII. Advisory Workgroup Updates

The Quality Assurance workgroup is a forum to bring consumers and providers in to help put together the quality assurance plan. The mission of the QA workgroup is to make recommendations to the larger committee regarding:

- Defining the priority health and mental health outcomes that will be monitored by this managed care initiative.
- Linking outcome variables to the goals of the program.
- Developing a process by which outcome data is utilized for quality improvement.
- Developing methods to measure and collect outcome variables.
- Reviewing Encounter Data Requirements.
- Federal Medicaid Managed Care External Quality Review Organization (EQRO) Protocols.
- Involving consumers in quality assurance planning, including consumer satisfaction.
- Assessing adequacy of access to needed services.
- Making recommendations regarding quality assurance and quality standards in the contract.
- A final report with recommendations will be available to the advisory committee in December 2004.

The Rate Setting workgroup met last week and discussed the following:

- Data to be used in the rate setting formulas. Don stated that the data will be ready soon.

- The group is looking for detailed data on psychotropic medications.
- Diagnostic data for risk adjustment calculations.
- Reconciliation of rates.
- A report on iCare was presented.
- An analysis of the rate history for iCare will be provided for this advisory committee.
- Dave Beckfield described the various options that could be used for rate setting.
- Milliman (contracted accounting agency) will attend the next rate setting meeting.
- Discussed general timeline for rates. Should be finished by December 2004.

VIII. Next Steps

- Our next advisory meeting is scheduled for October 29th, from 9:00-12:00 in conference room 751 at 1 West Wilson Street.
- We will revisit the predictive model.
- A good deal of the meeting will be devoted to the specifics of developing an All In/Opt-Out enrollment model.
- Heidi Herzinger will discuss timelines for systems changes for the Dane SSI Managed Care Program.
- We will discuss how to identify individuals who do not qualify for the program such as persons with a developmental disability.